Delivering the Next **Generation** of Health Care

Advancing team-based management.
Coordinating across the continuum of care.
Maximizing quality and accountability.
Investing in innovation.

AmeriHealth Caritas

CARE IS THE HEART OF OUR WORK ℠

## National Home- and Community-Based Services (HCBS) Conference

Baltimore — August 31, 2017

Setting the Stage

- More than 10 million Americans are dually eligible for Medicare and Medicaid.

    - Poorest, sickest, and costliest beneficiaries.

    - Often receive fragmented, uncoordinated care due to program misalignments.

- In 2011, the Centers for Medicare & Medicaid Services (CMS) launched the Financial Alignment Initiative to test new models to integrate Medicare and Medicaid.

- CMS and states contract with Medicare-Medicaid plans (MMPs), which are responsible for managing the full range of covered services for dually eligible beneficiaries.

    - Ten states participate in demonstrations: CA, IL, MA, MI, NY, OH, RI, SC, TX, VA.

    - Demonstration enrollment is 391,440 as of June 2017; 31.2 percent of those eligible are enrolled.

AmeriHealth Caritas' National Footprint

States
17
and the District of Columbia

Members
5.7M

Associates
6K
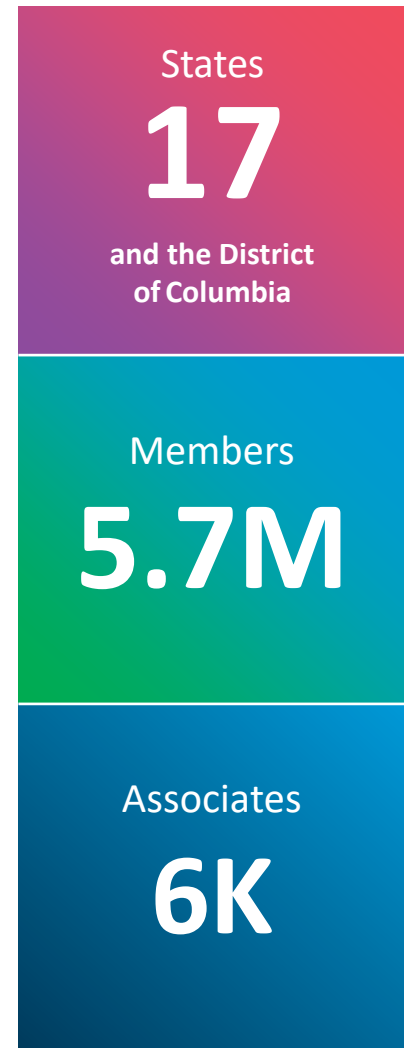
AmeriHealth Caritas' MMP Plans
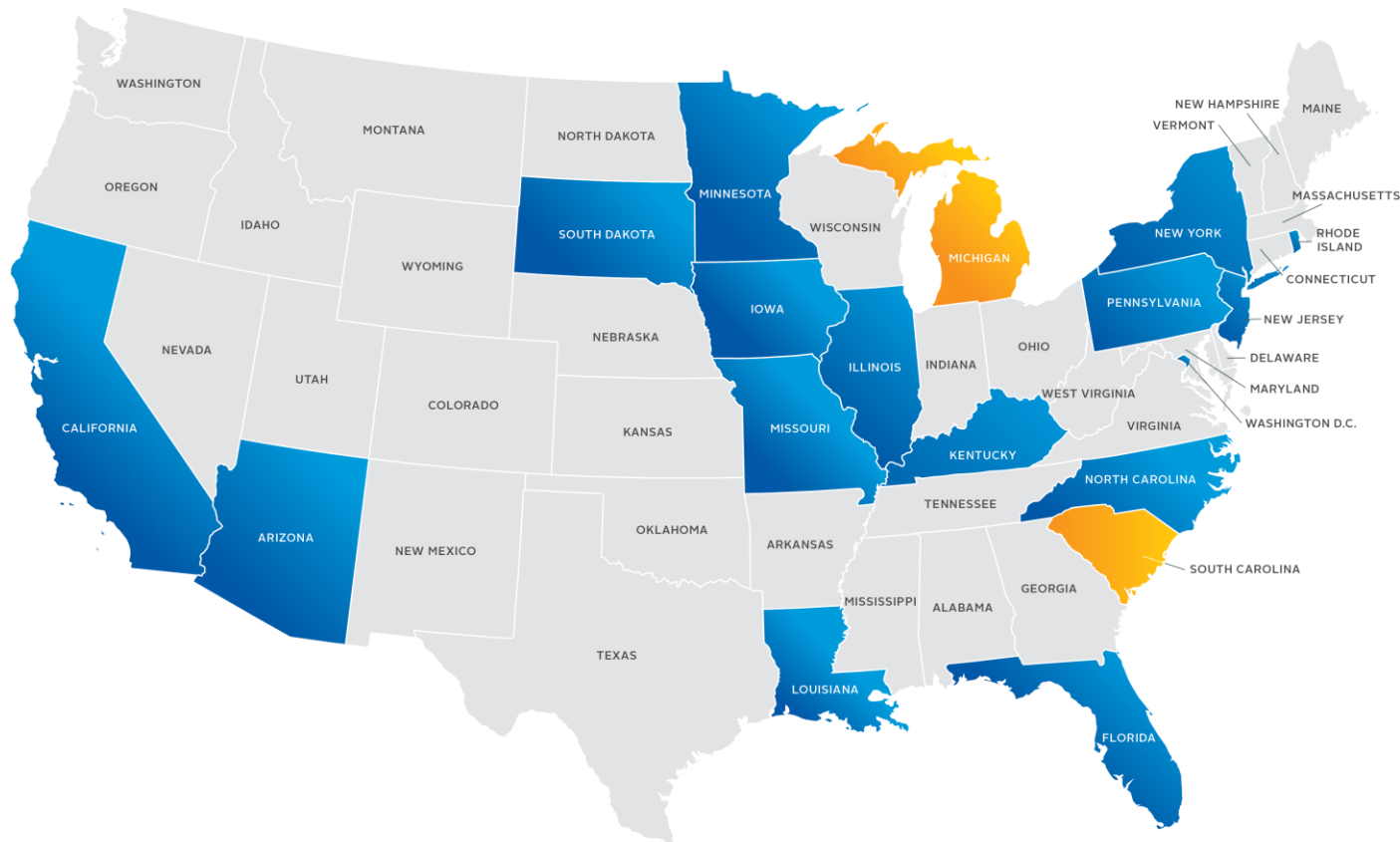
- AmeriHealth Caritas operates two MMPs.
- Key lessons learned for integrating care for dually eligible individuals.
- Fundamental takeaway: Policy and operational undertaking of this magnitude takes time and requires unmatched effort to develop structures, policies, and procedures to improve care.

Great Intentions: Lessons Learned

Healthy Connections Prime

August 31, 2017

Agenda

History & Background

Stakeholder Engagement

Program Design

- Person-Centeredness
- Support for Family Caregivers
- HCBS Integration
- Palliative Care
- Building Capacity and Core Competencies

Resources

History and Background

South Carolina's Initiative

Healthy Connections Prime Implemented: **February 2015**

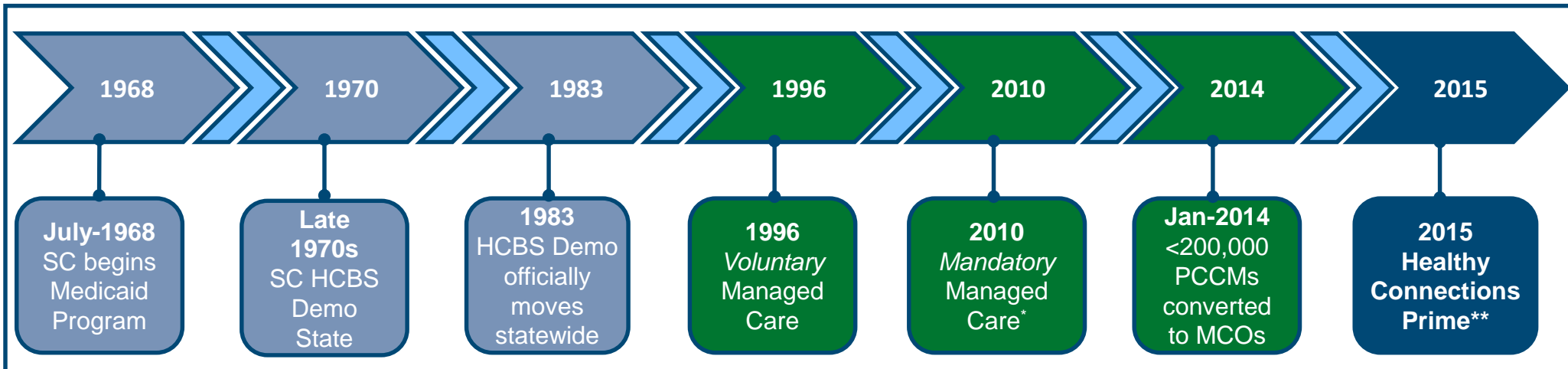Demographic: **Medicare-Medicaid Enrollees 65 years and older**

Current Membership: **11,468**

Model of care includes **full continuum** of Medicare and Medicaid services and leverages **person-centered care coordination** for all members
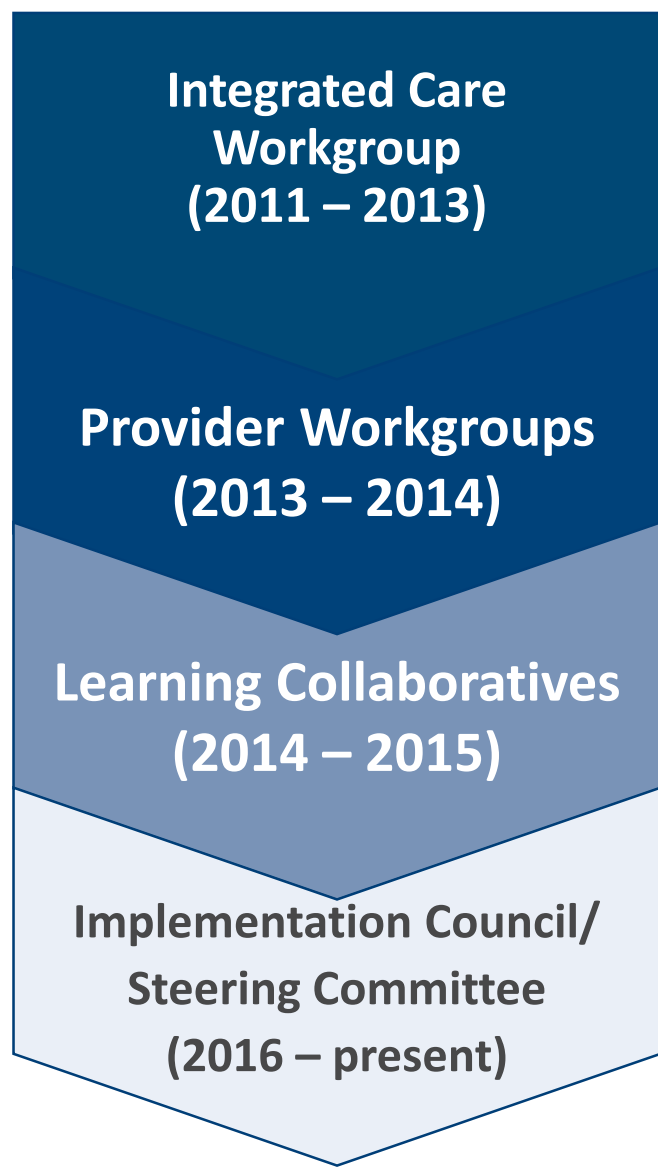
Three Medicare-Medicaid Plans (MMP)

Healthy Connections Prime is available
Healthy Connections Prime is not yet available

1968	1970	1983	1996	2010	2014	2015
July-1968 SC begins Medicaid Program	**Late 1970s** SC HCBS Demo State	**1983** HCBS Demo officially moves statewide	**1996** *Voluntary* Managed Care	**2010** *Mandatory* Managed Care*	**Jan-2014** <200,000 PCCMs converted to MCOs	**2015** Healthy Connections Prime**

*South Carolina's operated two coordinated care delivery models – managed care and primary care case management (PCCM). Some populations and services were excluded from managed care including dual eligibles, behavioral health, nursing facility and home and community services.

*Persons residing in a nursing facility at the time of enrollment or persons with enrolled in an waiver for individuals with intellectual or developmental disabilities are not eligible for enrollment.

Stakeholder Engagement

Integrated Care Workgroup (2011 – 2013)

Provider Workgroups (2013 – 2014)

Learning Collaboratives (2014 – 2015)

Implementation Council/ Steering Committee (2016 – present)

- Provided **input during planning** phase
- Determined **key program design features** *(i.e., demographic, population, geography)*

- Addressed specific needs primarily related to **long-term services and supports**

- Created platform to **exchange ideas and best practices** for health plans and providers

- Provides **meaningful feedback**
- Supports **dissemination of information** to broader stakeholder audience
- Inform on-going program activities as well as the **strategic plan** for long term program vision

Program Design: Person-Centeredness

Comprehensive assessment

Medicare-Medicaid Plans (MMPs) use **uniform assessment tool**

Conducted **face-to-face**, primarily in members' homes

94.5% completed within **90 days of enrollment***

Measures **psychosocial, functional, behavioral** health

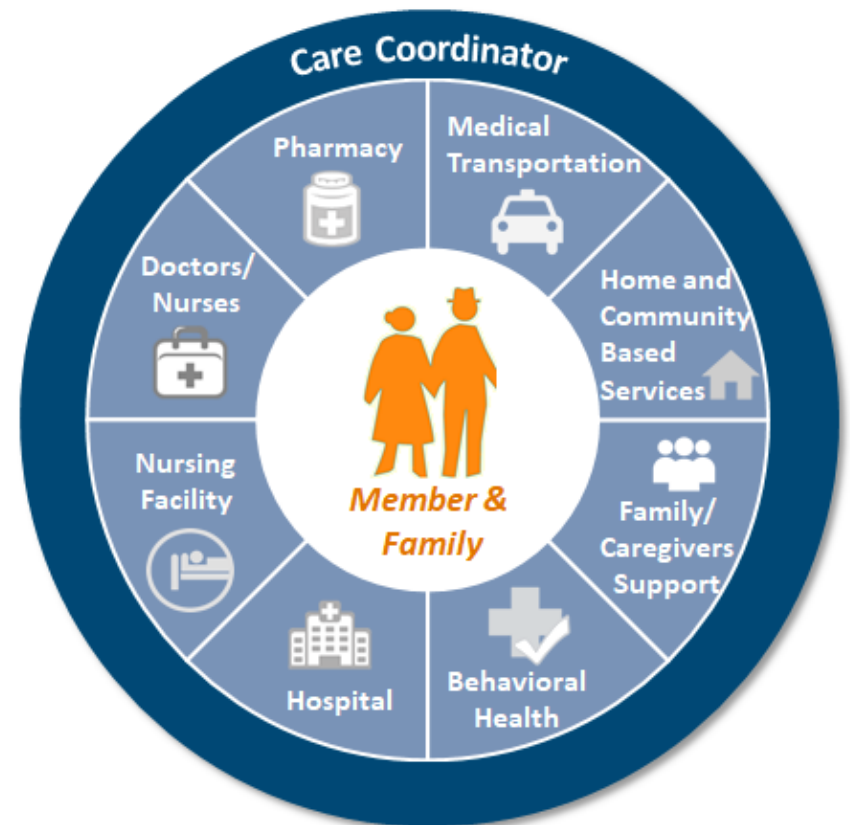Includes assessment of **home and caregiver supports**

Influences **individualized care plan**

Average member to care coordinator ratio: **1:120**

Multidisciplinary Team

Replaces **'rules based'** care management

Addresses **social determinants** of health (i.e., housing, food insecurity, transportation)

*Note: Source: MMP reported quarterly monitoring measure data. Measure data are provided for informational purposes only and do not constitute official evaluation results The number represents the percentage willing participate and who could be reached who had an assessment completed within 90 days of enrollment. Full measure specifications can be found in the core and state-specific reporting requirements documents, which are available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

Program Design: Family Caregivers

Healthy Connections Prime recognized by AARP for its:

Caregiver assessment

Care coordinator **training**

Quality measurements related to caregiver supports (i.e., required caregiver focused Quality Improvement Project)

AARP
Real Possibilities

"The caregiver-as-provider role places them in a critical position to affect outcomes that matter to the managed care organization."

South Carolina Caregivers

700,000 caregivers in SC

Care is valued at over **$7 billion**

Caregivers **arrange transportation, help with grocery, finances, meal prep, and housework**

Source: N., & A. (2015). 2015 Report: Caregiving in the U.S. Retrieved June 5, 2017, from http://www.aarp.org/content/dam/aarp/ppi/2015/caregiving-in-the-united-states-2015-report-revised.pdf
AARP. (2013). Long-Term Care in South Carolina. Retrieved June 5, 2017, from http://www.aarp.org/content/dam/aarp/research/surveys_statistics/general/2013/Long-Term-Care-in-South-Carolina-AARP-res-gen.pdf

Program Design: Palliative Care

New Benefit Under Demonstration

49% or 1,237 of members appropriate for palliative care received this benefit in 2016

Center for Advanced Palliative Care provided input on **messaging** of benefit in 2018 member material to promote quality of life

Prior Language		
"Advanced illness"	"Life-threatening injury	"End-of-life"

Updated Language

- Specialized medical care for "**people with serious illnesses**"
- Goal is to "improve **quality of life for both the patient and family**"
- Provides "**extra layer of support**" to patient's doctors
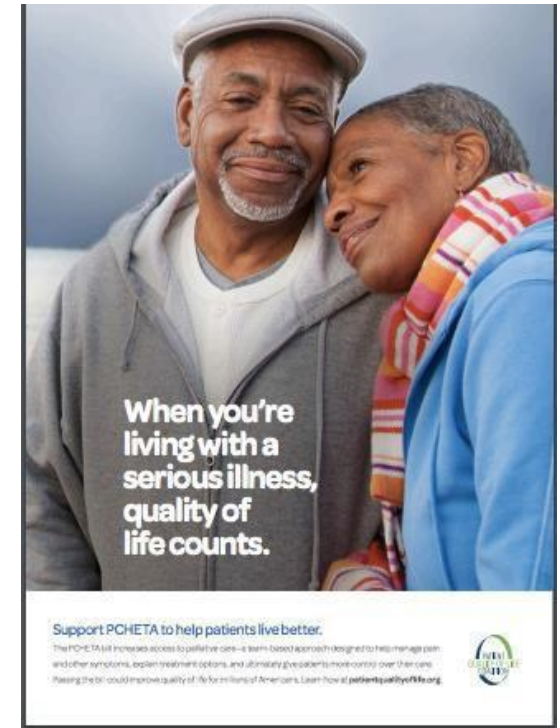- "Appropriate at **any stage** of serious illness"; can be "provided together with **curative treatment**"

Image by Patient Quality of Life Coalition

Program Design: HCBS Integration

Objective: Honor tenets of care integration and MMP capacity without compromising integrity of existing HCBS model

Approach

Seamless beneficiary experience by **building upon the 30-year history and infrastructure** to ensure system is not dismantled as the state progresses towards a sustainable transformation

Maintain parallel program in fee-for-service system for beneficiaries not enrolled

Consider **MMP capacity to manage HCBS** while fully integrating medical and behavioral health services → **Phased transition** of HCBS responsibilities to MMPs*

Incorporate **MMP benchmarks and readiness standards** at each phase

Desired Outcomes

- Decreased utilization of institutional care
- Increased waiver enrollment
- Rebalancing of long-term care expenditures

Experience To Date

- Average of **15% of members enrolled in waiver**
- MMPs leverage **HCBS-like services** for members who do not otherwise qualify for waiver services
- Increased **emphasis on respite**
- Challenge: Access to waiver **hindered by financial eligibility processing**

*Note: The state retains responsibility over provider compliance, the state's wavier case management system, and both the initial waiver assessment and the initial level of care determination.

Building Capacity and Core Competencies

MMP Trainings and Program Guidance

- **70 SCDHHS-sponsored trainings**, including those facilitated by the Office for the Study of Aging and other partners. (e.g., HCBS transition desk reference and Learning Collaboratives)
- **19 FAQs and memos**
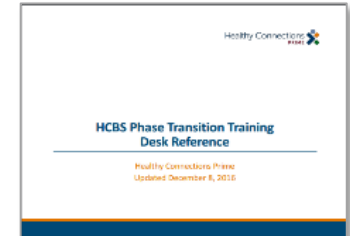
HCBS Desk Reference for MMPs

Provider Outreach

- **1,344 HCBS MMP contracted providers** representing 47.3% of all HCBS providers
- **35 trainings/presentations** to provider groups
- **17 notices and FAQs** on key issues

Guidance for Waiver Case Managers

Key Activities

- **E-Learning Management System** launched
- On-Line **Training Repository and Provider Tool Kits**
- MMPs required to complete **dementia competent training**

Resources

Training and Education

Dementia Dialogues | **Link**

MMP E-Learning Platform | **Link**
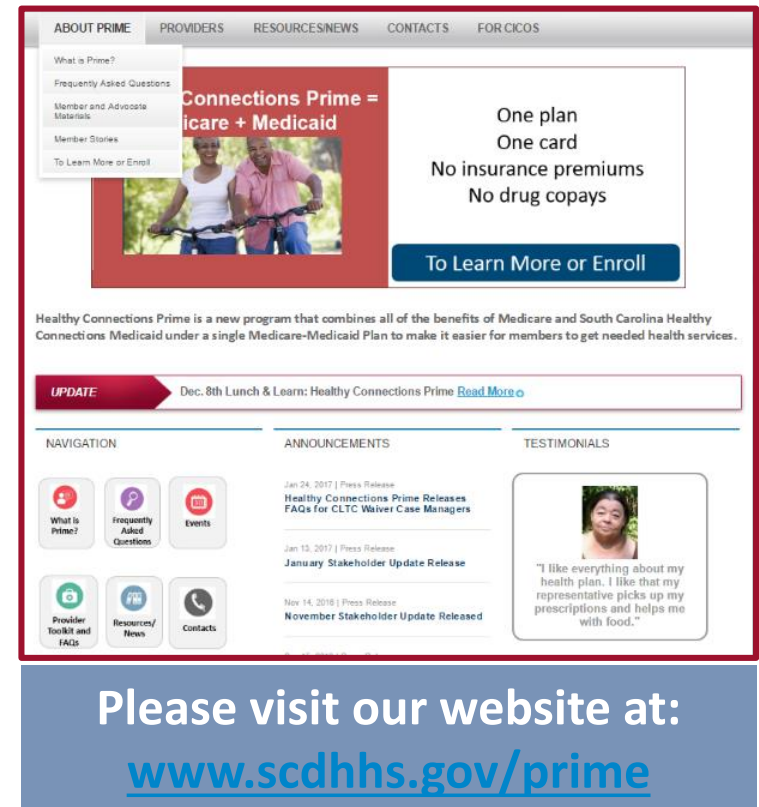
Program Guidance

Serious Reportable Events | **Link**

Emergency Preparedness | **Link**

HCBS Provider Transition FAQs | **Link**

Other

South Carolina Readiness Review Tool | **Link**

MMP Specific Program Guidance | **Link**

Please visit our website at:
www.scdhhs.gov/prime

Thank You!

Good Intentions: Lessons Learned

Integrated Care Coordination from an MMP's perspective

Jay N. Powell, FACHE

Vice President and Executive Director,
First Choice VIP Care Plus by Select Health of South Carolina (South Carolina MMP)

AmeriHealth Caritas®

Care is the heart of our work

Our History and Mission

Select Health of South Carolina is a part of the AmeriHealth Caritas Family of Companies — one of the nation's largest Medicaid managed care organizations. Through the First Choice health plan, we serve more than 350,000 members across South Carolina as one of the state's largest health plans.

Our mission-based, National Committee for Quality Assurance (NCQA)-recognized health care solutions make lasting improvements in the communities we serve by aiding those who need us most. With innovative community outreach solutions and access to our extensive network of providers, our members receive the commitment, attention, and health care they deserve.

Select Health launched First Choice VIP Care Plus as an MMP in February 2015. It is currently the largest Coordinated Integrated Care Organization (CICO) participating in Healthy Connections Prime, South Carolina's MMP with over 5,100 dual eligible members spread across 39 counties.

We help people get care, stay well, and build healthy communities.

First Choice VIP Care Plus Membership Mix

First Choice VIP Care Plus Member Mix (as of May 1, 2017)

■ Community ■ HCBS waiver ■ HCBS waiver-plus ■ Nursing facility ■ Total health plan membership

Community: 4,448
HCBS waiver: 650
HCBS waiver-plus: 2
Nursing facility: 33
Total health plan membership: 5,133

First Choice VIP Care Plus Membership Mix
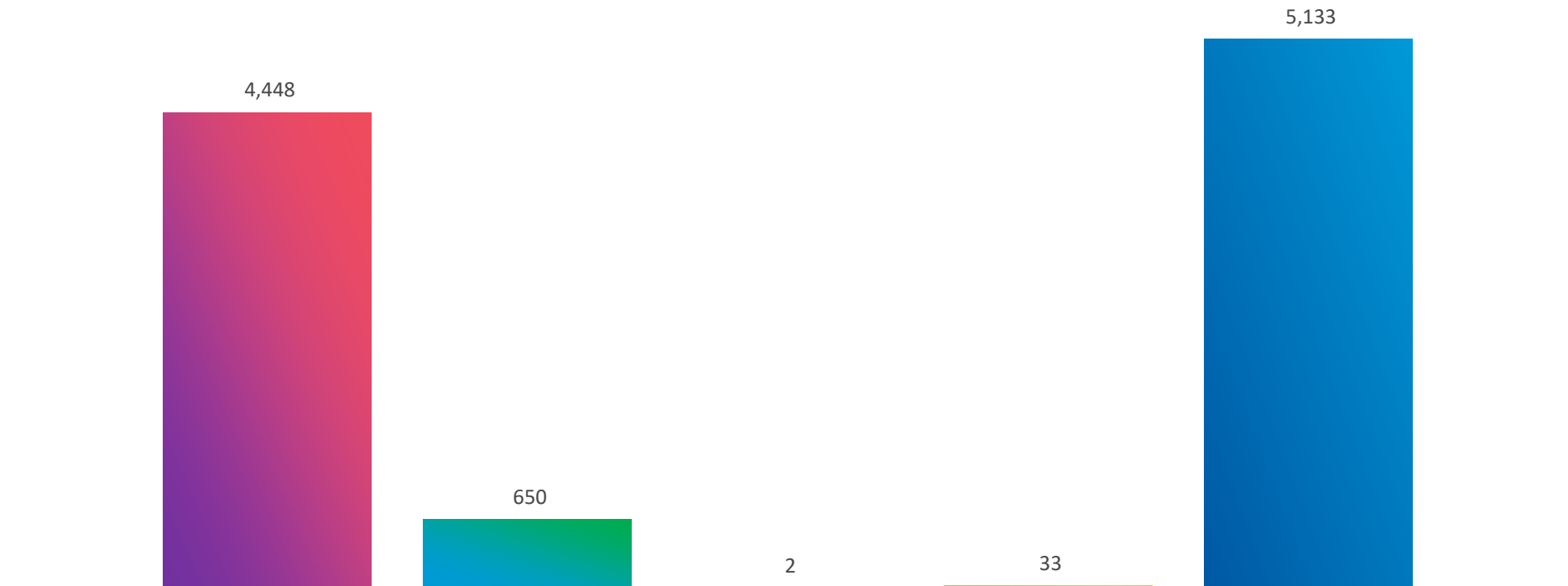
FirstChoice VIP CARE PLUS
by Select Health of South Carolina

August 2017 membership

5,133

Membership mix

- 50% — Ages 65 – 74
- 32% — Ages 75 – 84
- 18% — Ages 85 years and older

Market share

- 48.0% — First Choice VIP Care Plus
- 0% — Advicare
- 28.2% — Absolute Total Care
- 23.8% — Molina
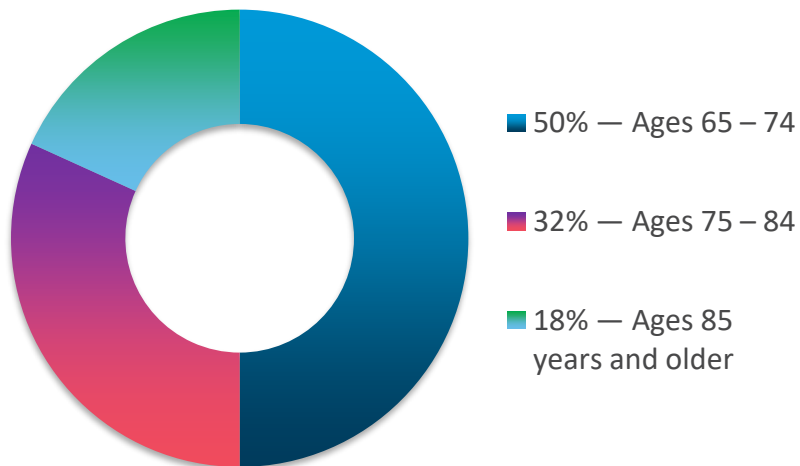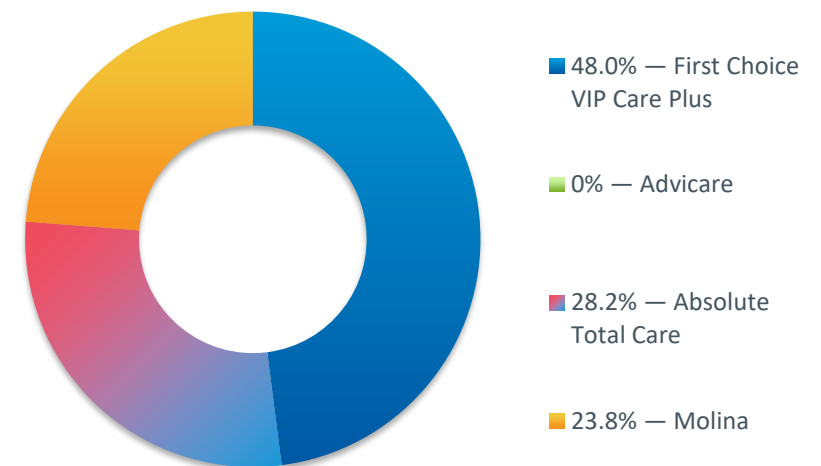
Good Intentions — The Model of Care Is Our Road Map

Lessons learned: One size does not fit all

The Model of Care is a living and breathing document.

- Medical complexity of membership is greater than expected.

- Person-centered planning evolves over time.

- Addressing social determinants is paramount.

- Issues in the dual eligible population that negatively impact health outcomes and increase costs include:

    - Frequent emergency room (ER) visits.

    - Hospital readmissions.

    - Poor medication adherence.

    - Lack of adequate and supportive housing.

    - Absent or limited caregiver support.

    - Opioid and illegal substance addiction.
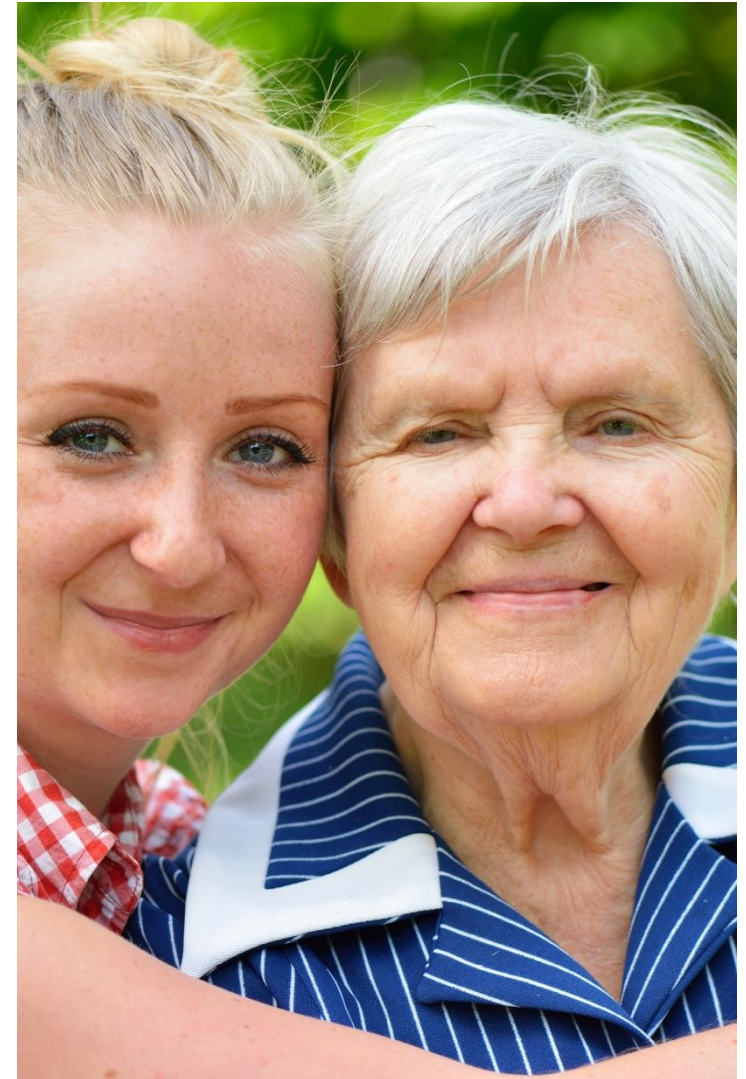
Good Intentions —
If We Build It, They Will Come

Lessons learned: Stakeholder engagement is key — it takes a village

Goal:
Collaboration among the care team, Care Coordinator, the member, and the multidisciplinary team yields **a Member Individual Care Plan** and a **Health Action Plan** that are specifically designed to meet the member's health and personal needs.

Example:
Kathy L. is a 78-year-old female with a history of coronary artery disease, obesity, and gastroesophageal reflux disease. She was recently diagnosed with stage II lung cancer. Kathy lives in a boarding home and receives HCBS. She is taking two high-risk medications (warfarin and diphenhydramine). Based on Kathy's medical diagnoses, new life-threatening condition, and minimal support system, as well as the presence of high-risk medications, her multidisciplinary team consists of:

Primary care provider (PCP) | Oncologist | Cardiologist | Pharmacist | Waiver case manager | Social worker | Community Health Navigator | Care Coordinator
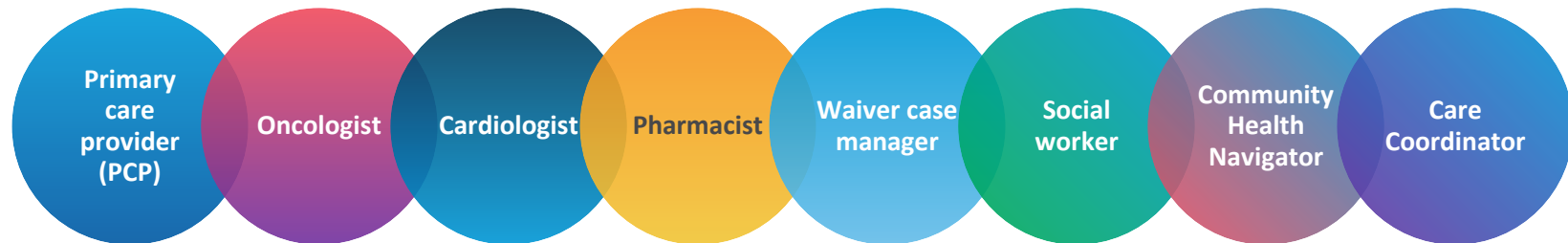
- Multiple care coordination entities with shared goals do not necessarily align organically. Stakeholders can align their goals by following some of these guidelines:
  - Decide who is in charge.
  - Put the person first: Members of the care team all have different relationships with the member, but what does the member really want?
  - Understand the importance of relationship-building and developing a common language.
  - Delineate internal and external roles.
  - Hold virtual multidisciplinary team meetings.
- Identify and refer members to community-based enabling services.

Good Intentions — The Three-Way Contract and Successful Integration

Lessons learned: Sound operational planning, readiness, and implementation is a "make it or break it" proposition

- Mitigate false starts and slow starts, which affect plan viability.

- Achieve critical mass to ensure program stability — learn how best to reduce opt-outs and accelerate opt-ins in a voluntary environment.

- Activate early, broad, and ongoing provider and stakeholder education and engagement.

- Reduce beneficiary assessment fatigue.

- Shift evaluation requirements from an activity-based focus to an outcomes-based focus.

- Increase integration between the federal government and states.

- Acquire additional data and time to evaluate cost savings and clinical outcomes.

- Early identify and address inevitable systems integration issues at the state and health plan levels.

- Use health plan electronic care management platforms and clinical data warehouses:

    - For health plans to rapidly expand and upgrade these systems to address long-term services and supports (LTSS) populations.

    - To resolve interface issues with existing state systems.
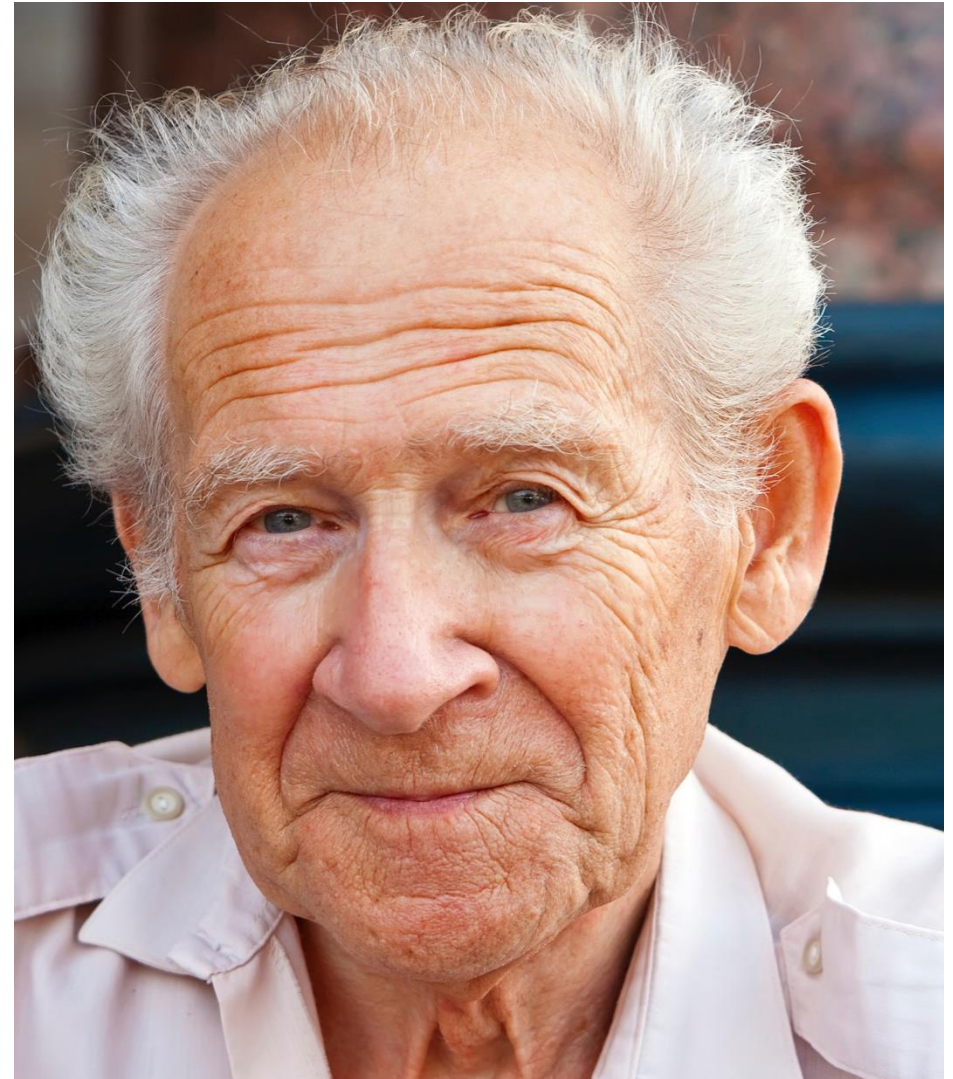
Innovations Achieved and Lessons Learned at MI Health Link

David R. Neff, DO
Chief Medical Director
Office of Medical Affairs
Medical Services Administration
Michigan Department of Health & Human Services

MI Health Link Demonstration

▶ MI Health Link (MHL) is a health care option for Michigan adults, ages 21 or over, who are enrolled in both Medicare and Medicaid (dual eligible), and live in one of four demonstration regions of Michigan.

▶ Offers a broad range of medical and behavioral health services, pharmacy, home and community-based services, and nursing home care, all in a single program designed to meet individual needs.

▶ The MHL Demonstration started March 1, 2015 and extends through December 31, 2020.

▶ 100,000 people eligible

▶ 37,000+ people enrolled

▶ Physical Health Medicaid Plans (7)

▶ Behavioral Health Medicaid Plans (4)

MHL Goal: Integration & Care Coordination

An organized and coordinated service delivery system across all service domains.

- ▶ Core Features

  - ▶ Person-Centered Care

  - ▶ Risk Indexing and Assessment

  - ▶ Personalized Care Plan

  - ▶ Coordinated Data Exchange

- ▶ Additional Features

  - ▶ Coordinated Medicare and Medicaid benefits

  - ▶ Reduced Fragmentation of Supports & Services

  - ▶ Home and Community-Based Services

  - ▶ Integrated Physical and Behavioral Health

  - ▶ Quality Services Focused on Enrollee Satisfaction

Integrated Care

MI HEALTH LINK
Linking Medicare and Medicaid for you

Integrated Care Team

Providers

MEDICARE
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Skilled Nursing Facility

Personal Care Services

Behavioral Health Plan

Enrollee/ Care Coordinator

Social Services

MEDICAID
MDHHS
Michigan Department of Health & Human Services

Adult Foster Care

Long Term Services & Supports

Family/Guardian

7 Integrated Care Organizations (ICO's)

AmeriHealth Caritas
VIP Care Plus

Care Plan Management

Enrollee

▶ Empowered to plan their life course and care needs

▶ Engages in developing a personalized plan

▶ Owns the plan

▶ Shares the plan with the team

▶ Works closely with the Care Coordinator

▶ Supported by the team to achieve their goals

▶ Updates the plan as needed with the care coordinator

Integrated Care Team

Providers

Skilled Nursing Facility

Personal Care Services

Behavioral Health Plan

Enrollee/ Care Coordinator

Social Services

Adult Foster Care

Family/Guardian

Long Term Services & Supports

Care Plan Management

Care Coordinator

▶ Care Coordinator as life coach to empower and enable the enrollee

▶ Facilitates the creation of comprehensive person-centered care plan

▶ Keeper of the care plan (source of truth)

▶ Receives new or updated information

▶ Identifies method to share plan with enrollee and care team (fax, email, portal view, electronic exchange)

▶ Distributes new or updated information to the team

Integrated Care Team

- Providers
- Personal Care Services
- Social Services
- Long Term Services & Supports
- Family/Guardian
- Adult Foster Care
- Behavioral Health Plan
- Skilled Nursing Facility

Enrollee/Care Coordinator

Care Plan Management

Care Plan

▶ Starts with Evaluating Needs Through Level I and Level II Assessments

▶ Enrollees preferences for care services and support

▶ Enrollees prioritized list of concerns, goals, objectives and strengths

▶ Summary of health status

▶ Plan for addressing concerns or goals

▶ Person(s) responsible for interventions, monitoring and reassessments

➕ Allergies	📄 Level I Assessment - August 10, 2015
♡ Integrated Conditions	📄 Level II Assessment Referral Response
🩺 Integrated Care Team	🚑 NFLOCD
💗 Individual Integrated Care and Support Plan	🏥 Social History
📅 Initial Screening - October 10, 2014	💊 Medications

The Care Bridge "ICBR" – Transferring Data Back and Forth Between ICO's and PIHP's

Michigan has a bifurcated physical and behavioral health Medicaid managed care plan system

Care Plan Management

The Care Plan Leverages the Consolidated Clinical Document Architecture (C-CDA)

▸ Standardizes the format and content of care plans for all enrollees

▸ Enables electronic sharing with care team members with EHRs

▸ Permits care team without EHRs to view and download through portals

▸ Allows for customization of care plan view

▸ Accommodates inclusion of additional health information
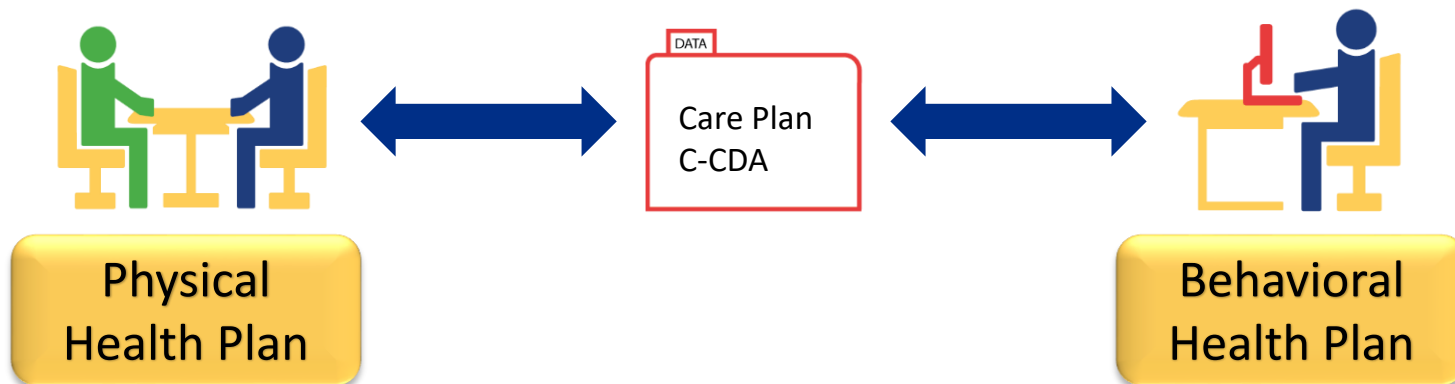
Future Care Plans Will Have Access to Better Information from the Michigan Health Information Network (MiHIN) & MDHHS Data Hub

MDHHS
Data Hub

- Immunizations
- MI Syndromic Surveillance System
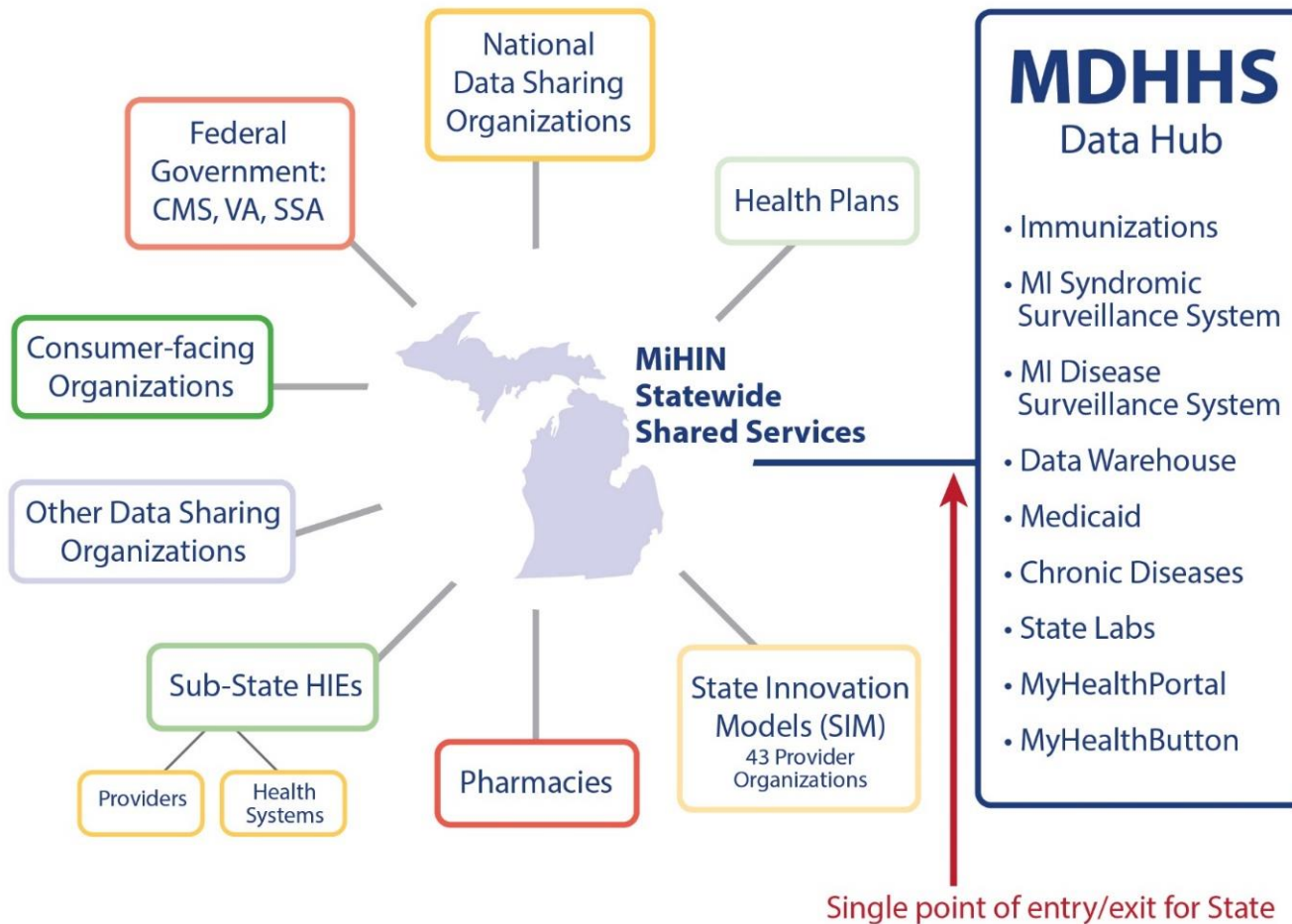- MI Disease Surveillance System
- Data Warehouse
- Medicaid
- Chronic Diseases
- State Labs
- MyHealthPortal
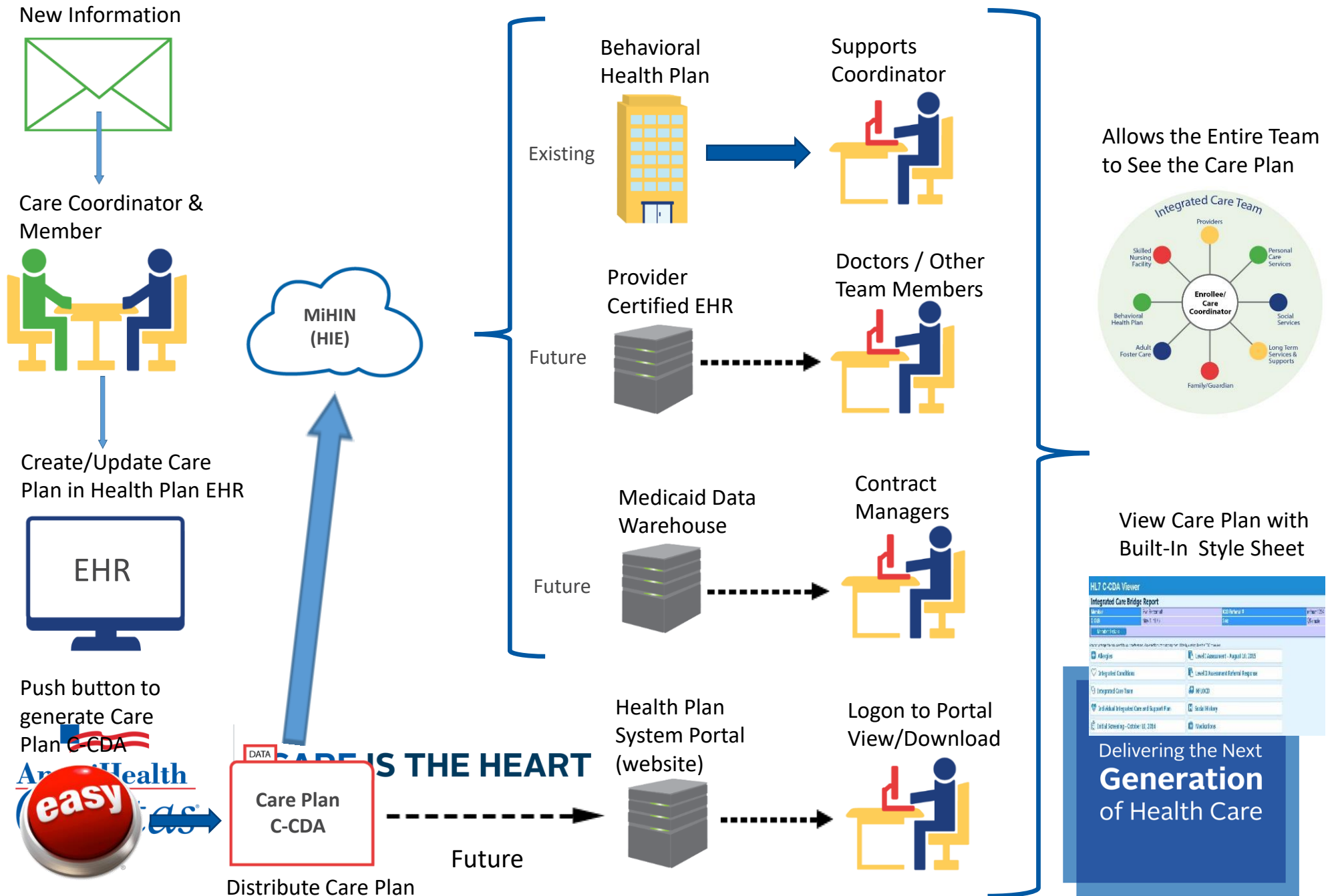- MyHealthButton

Single point of entry/exit for State

- Better Integration of Medicare Data
- Timely Admission, Discharge and Transfer (ADT) Data
- Risk Indexing
- Lab Data

MiHIN Shared Services is a network-of-networks

Present and Future Care Planning: Create, Update & Distribute

New Information

Care Coordinator & Member

Create/Update Care Plan in Health Plan EHR

EHR

Push button to generate Care Plan C-CDA

MiHIN (HIE)

DATA
Care Plan C-CDA

Distribute Care Plan

Existing

Behavioral Health Plan

Supports Coordinator

Future

Provider Certified EHR

Doctors / Other Team Members

Future

Medicaid Data Warehouse

Contract Managers

Health Plan System Portal (website)

Logon to Portal View/Download

Future

Allows the Entire Team to See the Care Plan

View Care Plan with Built-In Style Sheet

Delivering the Next **Generation** of Health Care

EASY BUTTON is a registered trademark of Staples The Office Superstore, LLC

Lessons Learned

1. Many enrollees who still feel like victims of their conditions and the system need to be empowered to engage
2. Care Coordinators can act as life coaches to empower their beneficiaries and guide the them on how to engage, but they need time to have meaningful conversations
3. Care Plans should be written by the beneficiary not by the health system imparting actions on their client
4. All team members need access to the Care Plan to best assist the enrollee achieve their goals and provide updates on their activities
5. Data needs to flow to all team members in a seamless manner to allow the enrollee and team to make accurate and timely decisions
6. For each beneficiary, data access should be limited to Care Team Members and Health Systems administrators – beneficiary level access to extended team members will be necessary

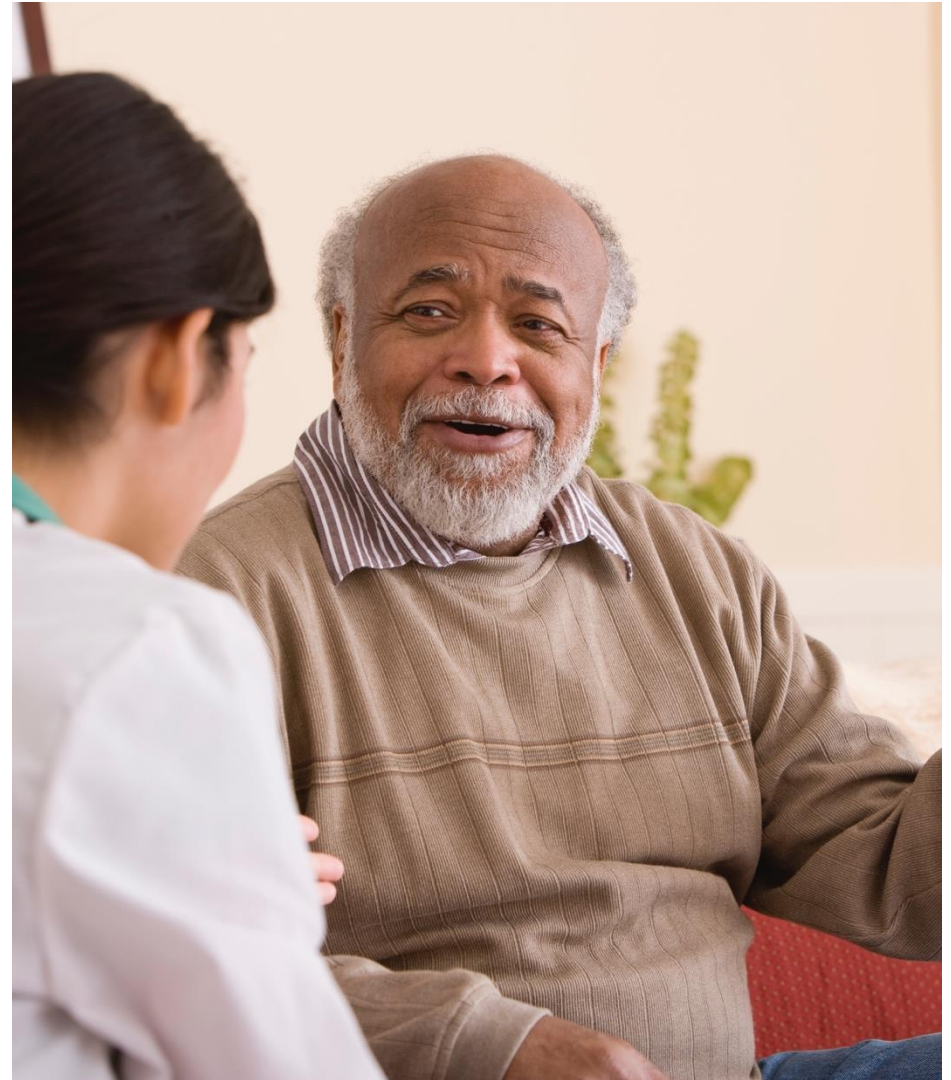# AmeriHealth Caritas VIP Care Plus

Care coordination model

Thomas Petroff, D.O., FACOOG

Acting Executive Director and Medical Director

AmeriHealth
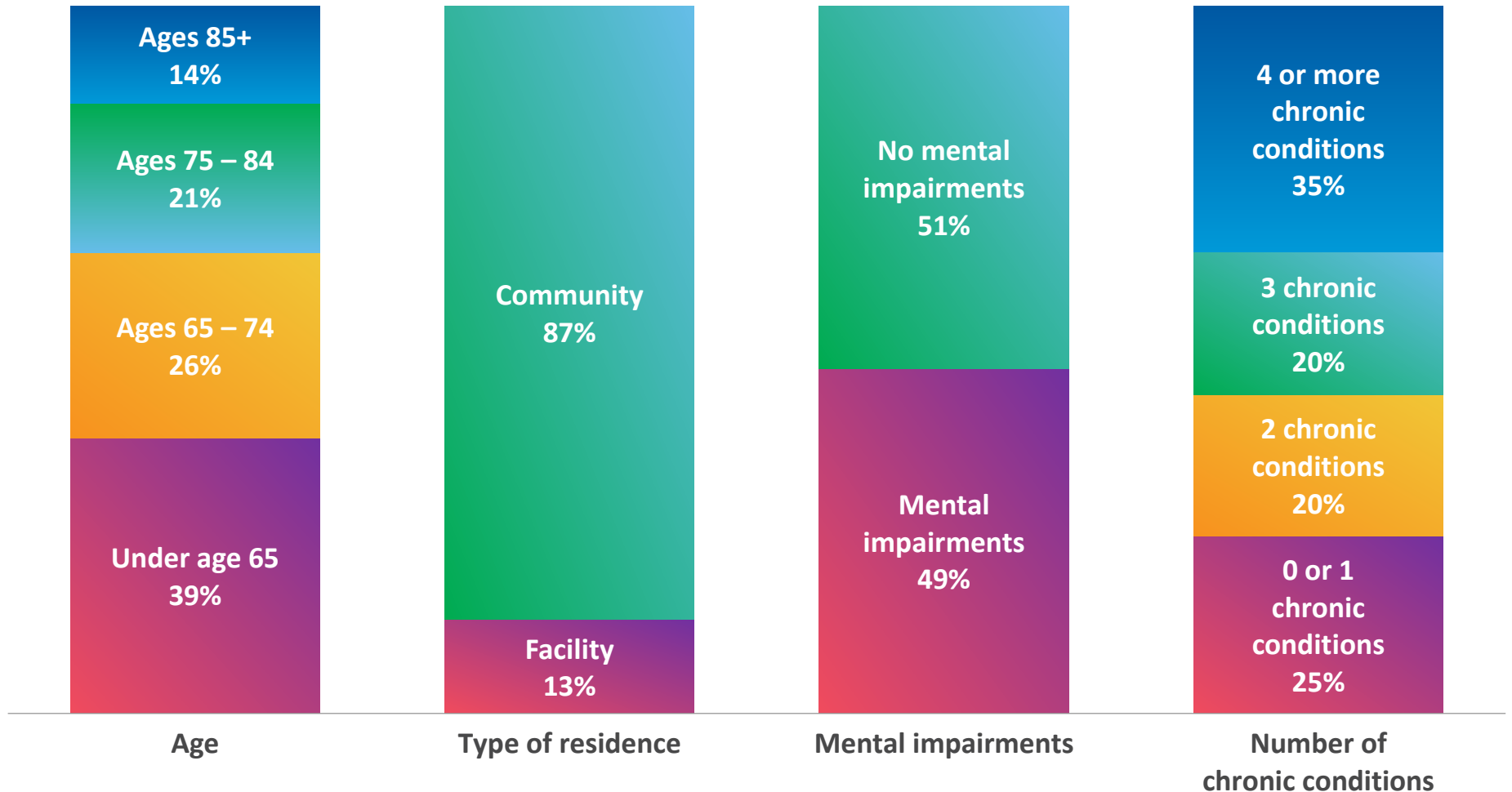Caritas®

Care is the heart of our work

AmeriHealth Caritas' Michigan MMP

- AmeriHealth Caritas VIP Care Plus is a program that joins Medicare and Medicaid benefits, rules, and payments into **one** coordinated delivery system.

- This plan represents a three-way agreement between CMS, Michigan Department of Community Health (MDCH), and procured integrated care organizations (ICOs).

- ICOs hold sub-contracts with prepaid inpatient health plans (PIHPs) for behavioral health care services.

- AmeriHealth Caritas VIP Care Plus operates in four regions in the state:
  - Two regions each in Wayne and Macomb counties.
  - 3,500 members.

# Model of Care — Why Dual Eligibles Are Special-Needs Members

AmeriHealth Caritas
Care is the heart of our work

Age
- Ages 85+ 14%
- Ages 75 – 84 21%
- Ages 65 – 74 26%
- Under age 65 39%

Type of residence
- Community 87%
- Facility 13%

Mental impairments
- No mental impairments 51%
- Mental impairments 49%

Number of chronic conditions
- 4 or more chronic conditions 35%
- 3 chronic conditions 20%
- 2 chronic conditions 20%
- 0 or 1 chronic conditions 25%

Note: Mental impairments were defined as Alzheimer's disease, dementia, depression, bipolar disorder, schizophrenia, or mental retardation.
Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey, 2008.

Integrated Care Approach

- The AmeriHealth Caritas VIP Care Plus Model of Care for MI Health Link is our plan for providing an integrated care management approach to health care delivery and coordination.

- The Model of Care is the "how" of AmeriHealth Caritas VIP Care Plus care coordination model.

Our Model of Care focuses on:

- Improving health outcomes.

- Access to essential services and affordable care.

- Coordination of care through the medical home and PCP.

- Access to preventive services.

- Seamless transitions.
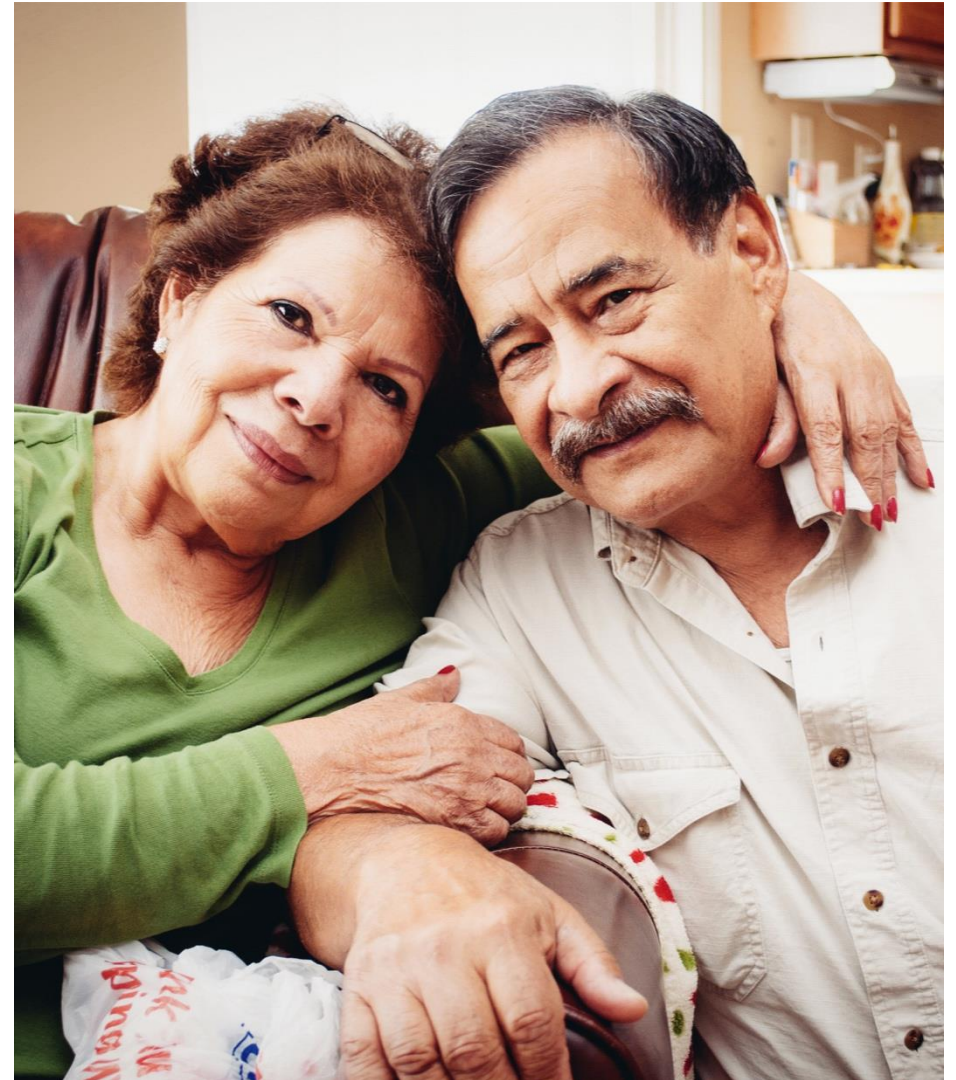
Integrated Care Approach

Goals:

- Improve health outcomes.
- Delay the need for nursing facility care.
- Reduce avoidable emergency department visits and hospital readmissions.
- Increase access to home- and community-based services.

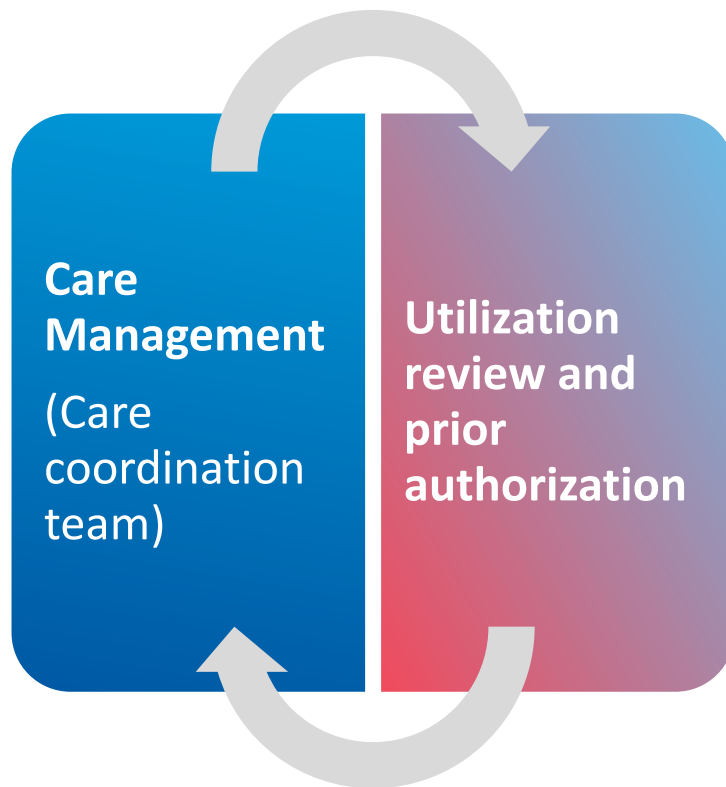## Benefits:

Single plan coverage and point of contact for:

- Medical care.
- Behavioral health care.
- Home- and community-based services and nursing home care.
- Medications.
- Care coordination.*

*Key benefit

AmeriHealth Caritas plans use a **Care Coordination team** to promote these goals and render the benefits. This team will get to know the member and help create a personal care plan based on the member's needs and goals. This team will connect the member with the supports and services they need to address their problems and goals.

Member Support

Medical management area

Care Management (Care coordination team) | Utilization review and prior authorization

Care Coordination team

- Supports Care Coordinator
- Care Coordinator
- Personal Care Connector
- Community Health Navigator

Integrated Care Approach:
Care Coordination Team

Community Health Navigators
- Are not clinicians.
- Work in the field to:
  - Locate members we could not reach by phone.
  - Support members needing extra assistance.
  - Assist members to identify and access community resources.

Supports Care Coordinator
- Is a registered nurse (R.N.) or social worker.
- Is a point of contact for LTSS or behavioral health matters.
- Conducts member assessments to help identify their needs, goals, preferences, and strengths.

Care Coordinator
- Is an R.N. or social worker.
- Is a point of contact for clinical matters.
- Conducts member assessments to help identify their needs, goals, preferences, and strengths.

Personal Care Connector
- Is a non-clinical customer service agent.
- Fields member phone calls.
- Is the first contact with the member and works in tandem with Community Health Navigators to:
  - Schedule PCP appointments.
  - Answer benefit questions.
  - Arrange for transportation.

Integrated Care Approach: Provider Collaboration

Working with AmeriHealth Caritas

Requests for skilled care (not room and board) and durable medical equipment (DME)

Providers should contact Utilization Management (UM) at designated intervals by phone or fax with the appropriate documents.

Requests for custodial authorization

Providers should contact Medical Management so they can determine the next steps in obtaining custodial authorization.

The Care Coordinator may need to assess the facility before providing authorization, or providers may only need to provide the signed and completed Freedom of Choice (FOC) with the 2565 form.

Assistance with transitions to home

Providers will work with both LTSS and Medical Management.

The LTSS team takes the lead on transitions to home and works very closely with Medical Management to make transitions seamless and successful.

Care coordination

Providers will work with Medical Management for care coordination.

Providers can contact Medical Management or Customer Service to identify which Care Coordinator is assigned to each member or facility.

Care coordination includes going to facilities and hospitals, participating in care conferences, and assisting with transitions from hospitals to either facilities or the community (home).

Good Intentions: Lessons Learned

Summary and Wrap-up

Suzie Bosstick

Director, Long-Term Services and Supports

AmeriHealth Caritas

Care is the heart of our work

Lessons Learned

Dual eligible members are often referred to as "super-utilizers," but the population is not homogeneous: the level of risk varies within the population and changes over time.

Successful integration requires:

- Nimbleness and the capacity to ensure the Model of Care supports a person-centered approach and recognizes varying risk factors and targets resources accordingly.

- Availability of real-time data to determine needed changes in the Model of Care.

- Integrated systems to support integrated care.

- Integrated data systems and warehouses to define and measure correct outcomes.

- The core of the Model of Care: member-centric care that focuses on quality of life, provides supports to sustain caregivers, and emphasizes palliative care.
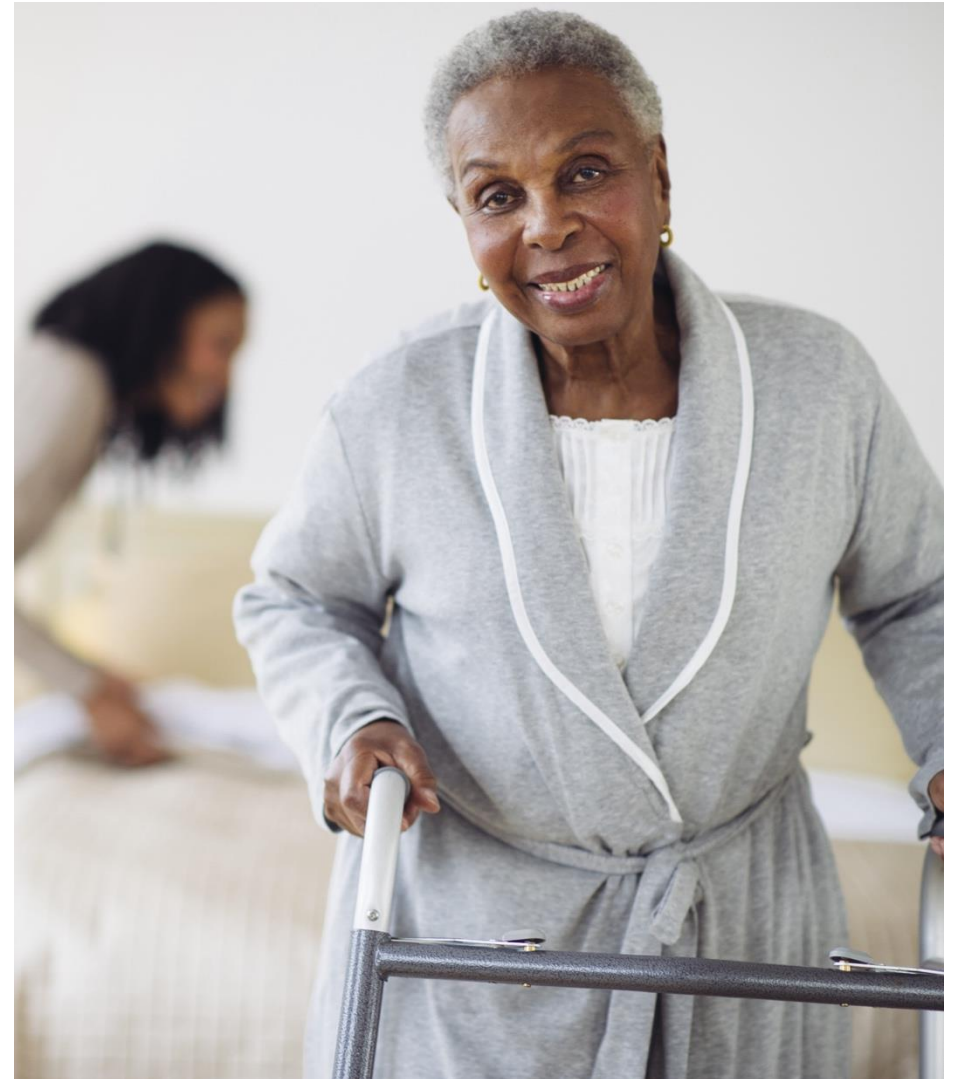
Lessons Learned

Successful integration requires (continued):

- Greater focus on measuring outcomes and less focus on process.

- Value-based partnerships with key influencers.

- Continuous, ongoing stakeholder education.

- Achieving critical mass for stability and sustainability:

  - A continuously enrolled population to effect individual health behavior change and health system change.

- Appropriate payment rates and incentives designed to drive outcomes.

- Alignment and integration at all levels:

  - Federal.

  - State.

  - Health plan.

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